

		FOR OHF USE					

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**2000  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0041756</u>  <b>Facility Name:</b> <u>Rosewood Care Center-Rockford</u>  <b>Address:</b> <u>1660 South Mulford Road</u> <u>Rockford</u> <u>61108</u> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Number</span> <span>City</span> <span>Zip Code</span> </div> <b>County:</b> <u>Winnebago</u>  <b>Telephone Number:</b> <u>( 815 ) 397-8700</u> <b>Fax #</b> <u>( )</u>  <b>IDPA ID Number:</b> <u>041756</u>  <b>Date of Initial License for Current Owners:</b> <u>05/20/96</u>  <b>Type of Ownership:</b>  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> _____         </div> <div> <input checked="" type="checkbox"/> <b>PROPRIETARY</b>  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input checked="" type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </div> <div> <input type="checkbox"/> <b>GOVERNMENTAL</b>  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </div> </div>	
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**In the event there are further questions about this report, please contact:**  
**Name:** Cindy A. Tefteller **Telephone Number:** ( 618 ) 465-7717

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

**Print Preview**



Facility Name & ID Number Rosewood Care Center-Rockford# 0041756 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>10,572</u>	<u>10,572</u>	8
9	SNF/PED					9
10	ICF	<u>1,880</u>	<u>13,615</u>		<u>15,495</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,880</u>	<u>13,615</u>	<u>10,572</u>	<u>26,067</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4 59.35%)D. How many bed-hold days during this year were paid by Public Aid?  
None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started 05/20/96J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 05/20/96 NO ☐K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 50 and days of care provided 10572Medicare Intermediary Tri-Span

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Rosewood Care Center-Rockford # 0041756 Report Period Beginning: 07/01/1999 Ending: 06/30/2000  
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	162,614	14,345	10,039	186,998		186,998	0	186,998		1
2	Food Purchase		114,303		114,303		114,303	(5,561)	108,742		2
3	Housekeeping	117,209	15,160		132,369		132,369	0	132,369		3
4	Laundry	32,337	8,678		41,015		41,015	0	41,015		4
5	Heat and Other Utilities			86,099	86,099		86,099	0	86,099		5
6	Maintenance	21,716	10,048	44,012	75,776		75,776	3,538	79,314		6
7	Other (specify): Sanitation			10,172	10,172		10,172	0	10,172		7
8	<b>TOTAL General Services</b>	333,876	162,534	150,322	646,732		646,732	(2,023)	644,709		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,200	13,200		13,200	0	13,200		9
10	Nursing and Medical Records	1,350,695	189,202	181,640	1,721,537		1,721,537	0	1,721,537		10
10a	Therapy	22,035	2,684	433,643	458,362		458,362	67,998	526,360		10a
11	Activities	38,383	3,745	3,500	45,628		45,628	0	45,628		11
12	Social Services	37,118		3,000	40,118		40,118	0	40,118		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	<b>TOTAL Health Care and Progra</b>	1,448,231	195,631	634,983	2,278,845		2,278,845	67,998	2,346,843		16
	<b>C. General Administration</b>										
17	Administrative			132,000	132,000		132,000	(2,125)	129,875		17
18	Directors Fees							0			18
19	Professional Services			6,449	6,449		6,449	53,102	59,551		19
20	Dues, Fees, Subscriptions & Promotions			24,951	24,951		24,951	(9,128)	15,823		20
21	Clerical & General Office Expense	127,940	29,725	36,112	193,777		193,777	171,162	364,939		21
22	Employee Benefits & Payroll Taxes			282,979	282,979		282,979	29,044	312,023		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			1,578	1,578		1,578	(447)	1,131		24
25	Other Admin. Staff Transportation			11,017	11,017		11,017	59,626	70,643		25
26	Insurance-Prop.Liab.Malpractice			29,102	29,102		29,102	3,781	32,883		26
27	Other (specify):*							0			27
28	<b>TOTAL General Administration</b>	127,940	29,725	524,188	681,853		681,853	305,015	986,868		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,910,047	387,890	1,309,493	3,607,430		3,607,430	370,990	3,978,420		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATION REPORT  
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Rosewood Care Center-Rockford # 0041756 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation							222,194	222,194		30
31	Amortization of Pre-Op. & Org.							7,658	7,658		31
32	Interest			128,186	128,186		128,186	289,208	417,394		32
33	Real Estate Taxes			103,805	103,805		103,805	0	103,805		33
34	Rent-Facility & Grounds			676,412	676,412		676,412	(665,939)	10,473		34
35	Rent-Equipment & Vehicles							0			35
36	Other (specify):*							0			36
37	TOTAL Ownership			908,403	908,403		908,403	(146,879)	761,524		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		87,732	30,731	118,463		118,463	0	118,463		39
40	Barber and Beauty Shops			14,292	14,292		14,292	0	14,292		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		87,732	110,903	198,635		198,635		198,635		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,910,047	475,622	2,328,799	4,714,468	0	4,714,468	224,111	4,938,579		45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Rosewood Care Center-Rockford**

# **0041756**

Report Period Beginning: **07/01/1999**

Ending: **6/30/2000**

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	<b>NON-ALLOWABLE EXPENSES</b>				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(5,265)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,664)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(296)	2		13
14	Non-Care Related Interest	(128,141)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(447)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,817)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,311)	20		28
29	Other-Attach Schedule <u>Marketing Salary</u>	(49,489)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (195,430)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	419,541	Var	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 419,541		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 224,111		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview





**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.**

**IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Rosewood Care Center-Rockford

# 0041756 Report Period Beginning:

07/01/1999

Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary		Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
		<b>A. General Services</b>													
1		Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2		Food Purchase	(5,561)	0	0	0	0	0	0	0	0	0	0	(5,561)	2
3		Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4		Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5		Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6		Maintenance	0	0	3,538	0	0	0	0	0	0	0	0	3,538	6
7		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8		<b>TOTAL General Services</b>	<b>(5,561)</b>	<b>0</b>	<b>3,538</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,023)</b>	<b>8</b>
		<b>B. Health Care and Programs</b>													
9		Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10		Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a		Therapy	0	67,998	0	0	0	0	0	0	0	0	0	67,998	10a
11		Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12		Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13		Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14		Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16		<b>TOTAL Health Care and Program</b>	<b>0</b>	<b>67,998</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>67,998</b>	<b>16</b>
		<b>C. General Administration</b>													
17		Administrative	0	(112,000)	109,875	0	0	0	0	0	0	0	0	(2,125)	17
18		Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19		Professional Services	0	0	53,102	0	0	0	0	0	0	0	0	53,102	19
20		Fees, Subscriptions & Promotions	(9,128)	0	0	0	0	0	0	0	0	0	0	(9,128)	20
21		Clerical & General Office Expenses	(52,153)	470	222,845	0	0	0	0	0	0	0	0	171,162	21
22		Employee Benefits & Payroll Taxes	0	290	28,754	0	0	0	0	0	0	0	0	29,044	22
23		Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24		Travel and Seminar	(447)	0	0	0	0	0	0	0	0	0	0	(447)	24
25		Other Admin. Staff Transportation	0	0	59,626	0	0	0	0	0	0	0	0	59,626	25
26		Insurance-Prop.Liab.Malpractice	0	0	3,781	0	0	0	0	0	0	0	0	3,781	26
27		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28		<b>TOTAL General Administration</b>	<b>(61,728)</b>	<b>(111,240)</b>	<b>477,983</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>305,015</b>	<b>28</b>
29		<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(67,289)</b>	<b>(43,242)</b>	<b>481,521</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>370,990</b>	<b>29</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center-Rockford

# 0041756

Report Period Beginning:

07/01/1999 Ending:

06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	201,441	20,753	0	0	0	0	0	0	0	0	222,194	30
31	Amortization of Pre-Op. & Org.	0	7,658	0	0	0	0	0	0	0	0	0	7,658	31
32	Interest	(128,141)	417,349	0	0	0	0	0	0	0	0	0	289,208	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(676,412)	10,473	0	0	0	0	0	0	0	0	(665,939)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(128,141)</b>	<b>(49,964)</b>	<b>31,226</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(146,879)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(195,430)</b>	<b>(93,206)</b>	<b>512,747</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>224,111</b>	<b>45</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT



## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 109,875	\$ 109,875
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	222,845	222,845
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	28,754	28,754
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	59,626	59,626
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	20,753	20,753
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	10,473	10,473
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	53,102	53,102
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	3,781	3,781
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	3,538	3,538
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 512,747	\$ * 512,747

Sum\_6A

109875  
222845  
28754  
59626  
20753  
10473  
53102  
3781  
3538

\* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT  
DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$		\$	\$ *	

Sum\_6B

\* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name &amp; ID Number Rosewood Care Center-Rockford

# 0041756

Report Period Beginn 07/01/1999 Ending: 06/30/2000

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$		\$	\$ *	

Sum\_6C

\* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6D

Facility Name & ID Number Rosewood Care Center-Rockford

# 0041756

Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6D

\* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	440,954	3	6.59%	Salary	\$ 28,858	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	155,651	3	6.59%	Salary	13,619	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,477		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

| the name(s)  
PORTS.

Facility Name & ID Number Rosewood Care Center-Rockford# 0041756 Report Period Beginning: 07/01/1999Ending: 5/30/2000

## VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number ( 314 ) 994-9070Fax Number ( 314 ) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation		
Line	Item	(i.e.,Days, Direct Cost	Total Units	Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6		
Reference		Square Feet)		Allocated Among	Allocated	in Column 6	Units			
1	17	Salaries - Officers	Total Cost	63,328,031	17	\$ 341,083	\$ 341,083	4,172,995	\$ 22,476	1
2	21	Salaries - Other	Total Cost	63,328,031	17	2,916,125	2,916,125	4,172,995	192,158	2
3	22	Payroll Taxes	Total Cost	63,328,031	17	221,266		4,172,995	14,580	3
4	22	Employee Benefits	Total Cost	63,328,031	17	87,376		4,172,995	5,758	4
5	25	Travel	Total Cost	63,328,031	17	123,502		4,172,995	8,138	5
6	30	Depreciation	Total Cost	63,328,031	17	273,812		4,172,995	18,043	6
7	34	Building Rent	Total Cost	63,328,031	17	158,940		4,172,995	10,473	7
8	19	Professional Services	Total Cost	63,328,031	17	805,860		4,172,995	53,102	8
9	21	Telephone	Total Cost	63,328,031	17	167,133		4,172,995	11,013	9
10	26	Insurance	Total Cost	63,328,031	17	57,385		4,172,995	3,781	10
11	21	Taxes & Licenses	Total Cost	63,328,031	17	7,008		4,172,995	462	11
12	21	Office Supplies	Total Cost	63,328,031	17	291,559		4,172,995	19,212	12
13	6	Maintenance	Total Cost	63,328,031	17	46,996		4,172,995	3,097	13
14	17	Direct - Admin	Direct Cost	1	1	87,399	87,399	1	87,399	14
15	17	Direct - Admin	Direct Cost	16	16	881,154	881,154	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	1	8,416		1	8,416	16
17	22	Direct - Payroll Taxes	Direct Cost	16	16	89,761		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	1	2,710		1	2,710	18
19	30	Direct - Depreciation	Direct Cost	16	16	29,800		0	0	19
20	25	Direct - Travel	Direct Cost	1	1	51,488		1	51,488	20
21	25	Direct - Travel	Direct Cost	16	16	182,311		0	0	21
22	6	Direct - Maintenance	Direct Cost	1	1	441		1	441	22
23	6	Direct - Maintenance	Direct Cost	16	16	7,988		0	0	23
24										24
25	TOTALS					\$ 6,839,513	\$ 4,225,761		\$ 512,747	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Mercantile Bank		X	Construction Financing	Varies	12/21/94	\$ 5,523,000	\$ 4,747,511		Prm + 1/4	\$ 437,605	1	
2	Less Related Party Interest Income Offset										(20,256)	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Union Planters Bank		X	Working Capital		10/15/97	500,000			Prm + 1/4	45	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 6,023,000	\$ 4,747,511			\$ 417,394	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 6,023,000	\$ 4,747,511			\$ 417,394	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number: **Rosewood Care Center-Rockford**# **0041756** Report Period Beginning: **07/01/1999** Ending: **06/30/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>108,700</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>102,705</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(5,995)</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>109,800</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>103,805</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<b>18,176</b>	8
	1996	<b>100,225</b>	9
	1997	<b>116,241</b>	10
	1998	<b>107,881</b>	11
	1999	<b>107,053</b>	12

**1998 Payment - \$49,179**

**1999 Payment - \$53,526**

**Accrual = 1/2 of 1999 payment remaining (53,527) + 1/2 of estimated 2000 tax bill (56,273)**

<b>FOR OFF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 1999 \$		13
14	PLUS APPEAL COST FROM LINE 5 \$		14
15	LESS REFUND FROM LINE 6 \$		15
16	AMOUNT TO USE FOR RATE CALCULATIC \$		16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,042 B. General Construction Type: Exterior Stucco Frame Wood Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: \$61,913 2. Number of Years Over Which it is Being Amortized: Loan Fees - 27 Mos; Org. - 60 Mos.

3. Current Period Amortization: 7,658 4. Dates Incurred: 06/18/95

Nature of Costs: Organization Costs - \$61,095; Organization Costs - \$818; Trustee Fee

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>41,042</u>	<u>1994</u>	<u>\$ 262,474</u>	1
2					2
3	<b>TOTALS</b>	<b>41,042</b>		<b>\$ 262,474</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Rosewood Care Center-Rockford

# 0041756

Report Period Beginning:

07/01/1995

Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1996	\$ 3,692,092	\$	40	\$ 92,302	\$ 92,302	\$ 384,592	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Left Turn Lane Street			1996	50,239		25	2,010	2,010	8,375	9
10	Parking Lot Paving			1996	95,573		25	3,823	3,823	15,929	10
11	Site Excavation			1996	83,290		25	3,332	3,332	13,883	11
12	Storm & Sanitary Sewers, and Site Water Line			1996	154,171		25	6,167	6,167	25,696	12
13	Sprinkler System			1996	24,160		25	966	966	4,025	13
14	Landscaping			1996	55,477		25	2,219	2,219	9,246	14
15	Architect Fees			1996	35,224		25	1,409	1,409	5,871	15
16	Site Work			1996	9,428		25	377	377	1,571	16
17	Contractor Fee			1996	21,047		25	842	842	3,508	17
18	Title Fee			1996	1,068		25	43	43	179	18
19	Builder's Risk			1996	2,159		25	86	86	358	19
20	Legal Fees			1996	1,851		25	74	74	308	20
21	Construction Interest			1996	29,594		25	1,184	1,184	4,933	21
22	Outdoor Signs, Monument Sign and Facility Signage			1996	14,259		10	1,426	1,426	5,942	22
23	Water Heater/Boiler/Hot Water Booster			1996	16,147		10	1,615	1,615	6,729	23
24	Emergency Generator			1996	29,359		10	2,936	2,936	12,233	24
25	Walk-In Cooler			1996	5,094		10	509	509	2,121	25
26	Alarm Annunciator, Fire Alarm System, Door Alarm			1996	29,030		10	2,903	2,903	12,096	26
27	Wallcovering & Painting			1996	67,810		10	6,781	6,781	28,254	27
28	Kitchen Exhaust Hoods			1996	6,883		10	688	688	2,867	28
29	Sinks/Drains			1996	6,712		10	671	671	2,796	29
30	Nurse Call System			1996	28,100		10	2,810	2,810	11,708	30
31	TV Cable & Antenna, Telephone & Paging Wiring			1996	70,140		10	7,014	7,014	29,225	31
32	Carpet			1996	8,915		10	892	892	3,717	32
33											33
34	Continued on Additional Page										34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$ 143,079	\$ 143,079	\$ 596,162	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Rosewood Care Center-Rockford

# 0041756

Report Period Beginning:

07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Leasehold Improvements - Management Company:										
10	Office Construction/Improvements			1995	504		5	101	101	504	10
11	Office Design			1995	46		5	10	10	46	11
12	Office Shelving			1996	108		4	26	26	108	12
13	Office Expansion			1996	476		4	119	119	476	13
14	Office Expansion			1997	1,275		3	405	405	1,275	14
15	Office Expansion			1998	719		3	240	240	426	15
16	Office Addition			1999	355		3	118	118	118	16
17	Door Locks			1999	177		3	34	34	34	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$ 1,053	\$ 1,053	\$ 2,987	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Rosewood Care Center-Rockford

# 0041756

Report Period Beginning:

07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Rosewood Care Center-Rockford# 0041756Report Period Beginning: 07/01/1999 Ending: 06/30/2000**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 657,998	\$	\$ 68,587	\$ 68,587	5-7 Yrs	\$ 290,039	37
38	Current Year Purchases	20,794		1,533	1,533	5-7 Yrs	1,533	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 678,792	\$	\$ 70,120	\$ 70,120		\$ 291,572	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSM Management	Various	Various	\$ 46,392	\$	\$ 7,942	\$ 7,942	5 Yrs	\$ 18,501	42
43										43
44										44
45										45
46	TOTALS			\$ 46,392	\$	\$ 7,942	\$ 7,942		\$ 18,501	46

**E. Summary of Care-Related Assets**

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 222,194	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 222,194	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 909,222	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58	Section Not Applicable	\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO16. Rental Amount for movable equipm: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_13. /2002 \$ \_\_\_\_\_14. /2003 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Rosewood Care Center-Rockford# 0041756

Report Period Beginning: 07/01/1999 Ending: 06/30/2000

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES  
DURING THIS REPORT  
PERIOD?☐ YES☐ NO

SECTION NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES

If "yes", please complete the remainder  
of this schedule. If "no", provide an  
explanation as to why this training was  
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE \_\_\_\_\_

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE \_\_\_\_\_

**B. EXPENSES****ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**In the box below record the amount of income your  
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**Print Preview**

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Facility Name & ID Number Rosewood Care Center-Rockford# 0041756 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	16,945	\$ 185,978	\$	16,945	\$ 185,978	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		2,960	63,170		2,960	63,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		18,641	252,493	2,684	18,641	255,177	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescripts				87,732		87,732	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Specialty Beds, X-Ray & Other (specify): Lab Fees	39-8				30,731			30,731	13
14	TOTAL			\$	38,546	\$ 532,372	\$ 90,416	38,546	\$ 622,788	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Rockford

STATE OF ILLINOIS

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XV. BALANCE SHEET - Unrestricted Operating Fund.

# 0041756

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

As of 06/30/2000

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 148,100	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,000 )	737,214		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,606		6
7	Other Prepaid Expenses	2,511		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Def Inc Tax Benefit	23,000		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 923,431	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 923,431	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 173,919	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	868,812		29
30	Accrued Salaries Payable	143,937		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,393		31
32	Accrued Real Estate Taxes(Sch.IX-B)	109,800		32
33	Accrued Interest Payable	128,141		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Rent	(1,190)		36
37	Accrued Income Tax	(146,918)		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,293,894	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,293,894	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (370,463)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 923,431	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

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**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (155,675)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (155,675)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(214,788)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (214,788)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (370,463)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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## STATE OF ILLINOIS

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Facility Name &amp; ID Number Rosewood Care Center-Rockford

# 0041756

Report Period Beginning: 07/01/1999

Ending:

06/30/2000

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,605,234	1
2	Discounts and Allowances for all Levels	(1,945,763)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,659,471	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,651,175	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,651,175	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,664	13
14	Non-Patient Meals	5,265	14
15	Telephone, Television and Radio	2,664	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 26,593	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,499	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,499	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Income</b>	12,942	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 12,942	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,364,680	30

2			
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	\$ 646,732	31
32	Health Care	2,278,845	32
33	General Administration	681,853	33
<b>B. Capital Expense</b>			
34	Ownership	908,403	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	132,755	35
36	Provider Participation Fee	65,880	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,714,468	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(349,788)	41
42	<b>Income Taxes</b>	135,000	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (214,788)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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